Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

The Science and the Art

TO THE EDITOR: There is substantial basis for the editorial concern (Trends in the science and the art [Editorial]. 128:152-153, Feb 1978) with Food and Drug Administration Commissioner Donald Kennedy's desire to limit the marketing of drugs solely to those proven effective "by rigorous experiment"—a desire that is suspect because of its implications to other services and procedures. Your thoughts serve as a needed reminder of the Osler tradition, which blended the old art of medicine with developing scientific accomplishments. Such a blend, notably lacking in our younger medical generation, continues to be an indispensable prerequisite to a sound medical education and a sound subsequent practice.[1]

Although the cost factor appears on the surface as the initiating impetus or pretext, it merely acted as a catalyst for the overly scientific emphasis. Even before we became aware of the maelstrom of economic woes, many in medicine began to conduct themselves as if all of medicine had reached the precision and vigor of an exact science, immune to the obsolescence of its hypotheses. Moreover, particularly in the last decade, there were inroads on the professionalism of medicine. There appeared a deluge of economists who labeled medicine a trade or business and de-emphasized its predominant role, relegating its humaneness to the background or often cynically dismissing it. Not-for-profit hospitals were singled out as "obviously an industry,"[2] projecting an image of ailing human beings as industrial commodities. Even some of our organizational leaders[3] joined in such conceptualization, disregarding the distinguishing profit motive which is the mainspring of the commonplace variety of business. This, of course, is not to deny the need of a prudent and selective retrenchment in health care but it also recognizes the growing mischief of a lack of concern for the worth of human health and life.

There has been little recognition of the need in medical centers and political circles of safeguards against the prevailing idolatry of medical science. Such a need is evident—and the February editorial draws particular attention to it—in the pronouncements of our medical colleagues in government. Because of such idolatry, the practitioner has a tough assignment in trying to remain humane and to practice the art of medicine.

Medicine represents, as A.M. Ludwig so aptly phrased it, "a blend of empirical observations, scientific knowledge, unproved assumptions and folklore."[4] The current data are often ambiguous. There are no unequivocal answers to all medical diagnosis or treatment. It is not very comforting to note the vanishing of expressed doubt and uncertainty that had pervaded earlier medical practice which admittedly was much less knowledgeable.

It is reasonable to assume that the recognition of our limitations, and they are many, would spawn some long overdue modesty and humility —safeguards worth meditating on. Such modesty and humility "that good scientists should have engraved in their very souls,"[5] coupled with the cultivation of humanism, would be likely to have a contagious, sobering effect on the public's interpretation and expectations and, thereby, its presently overpowering and misconstrued urge to seek a remedy for mishaps in legal channels. Moreover, through the proper adoption of such

an approach, physicians become tempered by an awareness of the self-assurance of true reality, worthy of a mature physician.

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REFERENCES

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2. Patterson KD, Vars RC Jr: Hospital rate regulation in Oregon: A policy analysis. Corvallis, Oregon State University, 1974
3. Sammons JH: American Medical News, February 6, 1978
4. Ludwig AM: The psychiatrist as a physician. JAMA 234: 603-604, Nov 10, 1975
5. Kilpatrick JJ: The (Portland) Oregonian, Dec. 17, 1975

Trends in Obstetrics

TO THE EDITOR: My long-time friend and colleague, Peter Hughes, was in a foul mood the other morning. "I'm going to quit doing OB," he grumbled over his midmorning cup of coffee. "It just isn't fun anymore. It's becoming mechanized and dehumanized. Added to that, there is the ever present threat of malpractice that makes me uncomfortable."

"It used to be that the attending physician was the captain of the ship in the OB department," continued friend Peter. "But now our importance is diluted by the OB nurse who hooks our OB patient to the fetal monitor almost as soon as she walks through the door. And then she may proceed to invade the uterine cavity as she screws an electrode into the baby's scalp, or shoves up an intrauterine catheter. Just let the squiggles on the fetal monitor tape get a little erratic, and she begins to look at me cross-eyed for not rushing the patient in for a cesarean section. I've had it. I'm quitting."

Are not these typical of the comments we have been hearing lately from colleagues who are getting ready to throw in their accoucheur's sponge, or preparing to put away their axis-traction forceps, their DeLee fetus scopes? They say "Let those young fellows take over with their fetal monitors, their repeated amniocenteses, their cesarean sections done at the drop of a late deceleration."

Yet there are some of us who hate the thought of giving up OB. We know the sheer joy of bringing a new life into the world, of hearing that first cry, of seeing that exultant look of happiness on the new mother's face.

We do have our moments of doubt. At times we wonder, as we try so hard to exercise patient nonintervention we were taught was the essence of obstetrical art, whether those old fundamental teachings are really worth clinging to when, indeed, it seems that obstetric aggressiveness is the order of the day.

There was a time, for example, when delivering a baby by cesarean section was an admission of defeat—for the mother as well as the physician. A day when we strove to develop our skill with forceps, and when the ability to deliver a difficult breech was looked upon as a worthy accomplishment. In that day maternal morbidity and mortality was the prime consideration.

Now we are in a period of rapid change. Obstetrics is becoming less of an art and more of a science. The availability of fetal monitoring; oxytocin challenge tests; laboratory evaluations of serum estriols, bilirubin and palmitic acid, and L/S ratios suggests that mechanical devices and esoteric scientific data are threatening to replace good old-fashioned clinical judgment.

Moreover, the rights of the fetus are now being equated with those of the mother. Sophisticated (and expensive) neonatal intensive care units and the rapidly rising star of the neonatologist bear witness to that.

We are sorry that friend Peter, and others like him, are deserting the ranks. Now those of us who intend to stay in this happy business of bringing babies into the world must accept the increased responsibility of applying the new technologies judiciously and appropriately. After all, it's still the attending physician, not the nurse or the electronic machine, who must make the judgment call. To do this wisely and well we may have to unlearn some of the old obstetrical dictums, reevaluate some of our practices and stay abreast of new developments.

We need to urge senior staffers like Pete to stick around long enough to temper the boundless enthusiasm for medical gadgets and invasive obstetrics—at least until the final answers are in.

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President Lincoln's Illness

TO THE EDITOR: The diagnosis of Marfan syndrome for President Lincoln [Schwartz H: Abraham Lincoln and cardiac decompensation—A preliminary report. West J Med 128:174-177, Feb 1978] seems very doubtful to me.